

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023085
STATE FILE NUMBER

JUL 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6511

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Montgomery	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Walshville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Length of stay in lb 23 Days	8 STREET ADDRESS None (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Edgar Middle Paris Last Arnold			4. DATE OF DEATH Month June Day 28 Year 1958	
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 27, 1895	9. AGE (In years last birthday) 62	F UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and state or country) Coffeen, Illinois /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Robert Arnold	13b. MOTHER'S MAIDEN NAME Emily Green	14. NAME OF HUSBAND OR WIFE Emily Arnold
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I	16. SOCIAL SECURITY NO. 334-09-5579	17. INFORMANT Address Emily Arnold--Walshville, Illinois
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Cerebral Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis	Autopsy
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Sept 5 58 to June 25 and last saw her alive on June 27 58 Death occurred at 2:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George J. Hawk	22b. ADDRESS 1001 Euclid	22c. DATE SIGNED June 28 58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/30/58	23c. NAME OF CEMETERY OR CREMATORY Hart Cemetery	23d. LOCATION (City, town, or county) (State) South Litchfield, Illinois
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24. FUNERAL DIRECTOR John J. Kossly ADDRESS E. St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. JUN 30 58	26. REGISTRAR'S SIGNATURE Carl Smith
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John J. Cassidy

Licensed Embalmer No. 6855

P. O. Address Cape St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.